REMARKS

Informal Matters

In his Interview Summary mailed May 2, 2003, the Examiner indicated that the Declaration of Charles C. Lewis and Terrance Moore could not be considered. Applicants respectfully submit that similar information disclosure declarations have been previously considered and made of record by the Patent Office in many other issued patents. The Examiner's attention is directed to the enclosed Exhibit A for the first page of each of U.S. Pat. Nos. 5,807,449, 5,968,297 and 6,411,203, wherein the acknowledgement of the information disclosure declaration is highlighted. Additionally, Applicants wish to point out that similar Declaration was considered by Examiner Vanel Frenel in the related U.S. Patent Application No. 09/812,703, titled "Methods for Collecting Fees for Healthcare Management Group" filed on the same date by the same inventors as the above-referenced application. The Examiner's attention is directed to the enclosed Exhibit B for the initialed Information Disclosure Statement. In view of this, Applicants respectfully request that the Declaration of Charles C. Lewis and Terrance Moore be considered and made of record.

35 U.S.C. §101 Rejection

Claims 1, 5-13, 17-25, 35 and 36 stand rejected under 35 U.S.C. §101 as being directed to non-statutory subject matter. This rejection is respectfully traversed.

Applicants have amended independent Claims 1, 13 and 25 to each include gathering data in a tangible medium, identifying from the tangible medium a physician at a greater risk, and modifying management behavior for the purpose of increasing profitability. These data-gathering and physician-identifying steps and the purpose behind the modifying behavior step does indicate application, involvement, usage or advancement of the technological arts. Thus, Claims 1, 13 and 25 as amended are directed to statutory subject matters. Claims 5-12 being dependent of Claim 1, Claims 17-24 being dependent of Claim 13, and Claims 35-36 being dependent of Claim 25 are also directed to statutory subject matters upon the amendments to Claims 1, 13 and 25. Clearly these method steps are directed to methods of doing business in the healthcare fields, and clearly, the claimed invention, as a whole, is within the technological arts.

Accordingly, Applicants respectfully request that the rejection of Claims 1, 5-13, 17-25, 35 and 36 under 35 U.S.C. §101 be withdrawn.

35 U.S.C. §112 Rejection

Claims 26-34 stand rejected under 35 U.S.C. §112, second paragraph, as being indefinite. This rejection is respectfully traversed.

Applicants have amended independent Claim 26 to address the concern related to sufficient antecedent basis for the limitation of "the ancillary medical networks" for Claims 26-34, dependent of Claim 25. Therefore, Claims 26-34 are definite. Accordingly, Applicants respectfully request that the rejection of Claims 26-34 under 35 U.S.C. §112, second paragraph, be withdrawn.

35 U.S.C. §102 Rejection

Claims 25-27, 35-37, and 46-49 stand rejected under 35 U.S.C. §102 as being anticipated by Freeman, Jr. et al. (U.S. Pat. No. 6,012,035, hereafter Freeman). This rejection is respectfully traversed.

Freeman describes a system and method for supporting delivery of health care. Specifically, Freeman describes a data switch and repository that records all of the transactions among the provider, insurance company and financial institution (see Col. 2, lines 50-55), and a method of utilizing such data switch and repository to support an agency-cooperative health care provision and management (see Col. 2, lines 8-26). Freeman fails to teach or suggest a method of optimizing the profitability of an insurance network having a plurality of physicians in a healthcare practice participating therein by managing medical costs. The system and method described in Freeman is directed to the purpose of effectuating the operation of a cooperative agency organization dedicated to health care provision and management amongst a plurality of entities (see Col. 3, lines 7-16) rather than optimizing the profitability of an insurance network.

In contrast, the present invention teaches a method of optimizing a health care insurance network and related systems. Such method and systems are focused on managing medical costs of participating physicians.

Applicants respectfully submit that Freeman describes a completely different system and method from what is claimed in the present invention. In fact, Freeman fails to teach each and every element of the present invention. Presented below are detailed remarks to each of the Examiner's comments (Items 11-20).

Item 11. As per Claim 25, Freeman describes different entities that are included in the health care delivery system and a data switch and repository interfaces among these entities to support the delivery (Col. 3, lines 10-15). Freeman further describes that the transactions taking place amongst different entities are monitored by management services to ensure the requirements set by the cooperative are met (Col. 9, lines 16-19), and that the overall cooperative is based upon a membership with mutual agreements to the cooperative business relationship (Col. 7, lines 38-52). Freeman fails to teach or suggest a method of optimizing the profitability of an insurance network, let alone gathering data or information regarding ancillary medical cost and modifying the participating physicians' management behavior regarding the ancillary medical costs that are not profitable for the insurance network.

Item 12, as per Claim 26, Freeman describes a data switch and repository that interfaces amongst different entities and records all transactions to support delivery of a cooperative health care provision (Col. 6, lines 35-41). Freeman fails to teach or suggest databases that provide ancillary medical cost information for analyzing and modifying in order to optimize the profitability of an insurance network.

Item 13, as per Claim 27, Freeman describes that the transactions taking place amongst different entities are monitored by management services to ensure the requirements set by the cooperative are met (Col. 9, lines 16-19). Freeman fails to teach or suggest a method of optimizing the profitability of an insurance network, let alone analyzing information regarding ancillary medical cost and further identifying at least one of the plurality of physicians whose management behavior regarding the ancillary medical costs are not profitable for the insurance network.

Item 14, as per Claim 35, Freeman describes a purchaser database that is built and maintained for the cooperative management system, and that database is updated with new

enrollment of health care users whenever a purchasing member has entered the cooperative (Col. 5, line 58 - Col. 6, line 7). Freeman fails to teach or suggest the method of Claim 25. Nor does Freeman teach or suggest updating the participating physician of new ancillary medical procedures that are more profitable to the insurance network. Freeman's database updating has nothing to do with new ancillary medical procedures.

Item 15, as per Claim 36, Freeman describes that the data switch and repository records each transaction amongst different entities and generate reports based on the transactions (Col. 8, lines 44-53). Freeman fails to teach or suggest the method of Claim 35. Nor does Freeman teach or suggest the groups from which the ancillary medical costs are taken for analyzing and modifying the participating physicians' management behavior in order to increase or optimize the profitability of an insurance network.

Item 16, as per Claim 37, Freeman describes a data switch and repository that interfaces amongst different entities and records all transactions to support delivery of a cooperative health care provision (Col. 6, lines 35-41). Freeman further describes that the transactions taking place amongst different entities are monitored by management services to ensure the requirements set by the cooperative are met, and that the management services also monitors the performance of each insurance company as well as comparative effectiveness of health care providers (Col. 9, line 16 – Col. 10, line 5). Freeman fails to teach a healthcare management optimization system (emphasis added). Freeman's system is directed to support the delivery of a cooperative health care provision and management rather than optimize the profitability of an insurance network. Specifically, Freeman fails to teach a first database comprising ancillary medical procedures preferred by the insurance network or an analyzer for comparing the preferred procedure with the ancillary medical costs of participating physicians thereby identifying non-preferred and non-profitable costs of the physicians.

Item 17, as per Claim 46, Freeman describes a medical delivery and accounting system (Figures 1 and 2). Freeman further describes that the database is updated whenever there is a change in enrollment data (Col. 6, lines 1-14) and that the transactions taking place amongst different entities are monitored by management services to ensure the requirements set by the cooperative are met (Col. 9, lines 16-21). Freeman fails to teach a healthcare management

optimization system (emphasis added). Freeman's system is directed to support the delivery of a cooperative health care provision and management rather than optimize the profitability of an insurance network Specifically, Freeman fails to teach an updater that updates the participating physician of any changes in the management of ancillary medical costs preferred by the insurance network. Nor does Freeman teach recommending means for recommending to participating physicians alternative ancillary medical procedures preferred by the insurance network.

Item 18, as per Claim 47, Freeman describes that the transactions taking place amongst different entities are monitored by management services to ensure the requirements set by the cooperative are met, and that the management services also monitors the performance of each insurance company as well as comparative effectiveness of health care providers (Col. 9, line 16 – Col. 10, line 5). Freeman fails to teach the system of Claim 46 as discussed above. Moreover, Freeman fails to teach a database comprising ancillary medical procedures preferred by the insurance network.

Item 19, as per Claim 48, Freeman describes that the transactions taking place amongst different entities are monitored by management services to ensure the requirements set by the cooperative are met, and that the management services also monitors the performance of each insurance company as well as comparative effectiveness of health care providers (Col. 9, line 16 – Col. 10, line 5). Freeman fails to teach the system of Claim 47 as discussed above. Moreover, Freeman fails to teach an analyzer for comparing the preferred ancillary medical procedure with the ancillary medical costs of participating physicians thereby identifying non-preferred and non-profitable costs of the physicians.

Item 20, as per Claim 49, Freeman describes that the transactions taking place amongst different entities are monitored by management services to ensure the requirements set by the cooperative are met, and that the management services also monitors the performance of each insurance company as well as comparative effectiveness of health care providers (Col. 9, line 16 – Col. 10, line 5). Freeman fails to teach the system of Claim 48 as discussed above. Moreover, Freeman fails to teach managing means responsive to the analyzer for managing the ancillary

medical costs of the participating physicians to ensure better profitability of the insurance network.

In view of the above remarks, Applicants believe that Freeman fails to disclose each and every element of the claimed invention and even teaches away from the present invention. Therefore, Freeman does not anticipate the present invention as claimed. Accordingly, Applicants respectfully request that the rejection of Claims 25-27, 35-37, and 46-49 under 35 U.S.C. §102 be withdrawn.

35 U.S.C. §103 Rejection

Claims 1, 2, 5-14, 17-23, 24, 38 and 50 stand rejected under 35 U.S.C. §103 as being unpatentable over Freeman in view of Segal. This rejection is respectfully traversed.

Applicants believe that the Examiner's rejection is improper for at least three reasons. First, each of Freeman and Segal fails to disclose or suggest what the Examiner alleges it discloses. Instead, Applicants believe that the Examiner has improperly taken elements from each of Freeman and Segal out of context. Second, because there is no evidence of motivation to combine these documents, Applicants believe that the Examiner has used improper hindsight by using Applicants' patent application disclosure as a road map to then piecemeal elements from these Freeman and Segal documents together in an attempt to reject the claims. Third, Applicants also believe that even if these documents were somehow combinable, the result of the combination would not be the claimed invention. In detail, Applicants wish to present the following remarks.

Freeman describes a system and method for supporting delivery of health care. Specifically, Freeman describes a data switch and repository that records all of the transactions among the provider, insurance company and financial institution (see Col. 2, lines 50-55), and a method of utilizing such data switch and repository to support an agency-cooperative health care provision and management (see Col. 2, lines 8-26). Freeman fails to teach or suggest a method of managing a healthcare practice participating in an insurance network to optimize the profitability of the healthcare practice with respect to a predetermined reimbursement amount for pharmacy costs or selected ancillary medical costs. Nor does Freeman teach or suggest a

healthcare management optimizing system. The system and method described in Freeman is directed to the purpose of effectuating the operation of a cooperative agency organization dedicated to health care provision and management amongst a plurality of entities (see Col. 3, lines 7-16) rather than optimizing the profitability of the healthcare practice.

Segal describes drug prescribing and drug use process in a pharmaceutical care system. Segal fails to teach anything regarding a method of managing a healthcare practice participating in an insurance network to optimize the profitability of the healthcare practice with respect to a predetermined reimbursement amount for pharmacy costs or selected ancillary medical costs. Nor does Segal teach or suggest a healthcare management optimizing system.

In contrast, the present invention teaches a method of managing a healthcare practice to optimize profitability of the healthcare practice and related systems. Such method and systems are focused on modifying participating physicians' management behavior regarding the pharmacy costs or ancillary medical costs to reduce the risk of not receiving the predetermined reimbursement amount from the insurance network and thereby increase profitability of the healthcare practice.

Item 23, as per Claim 1, Freeman describes different entities that are included in the health care delivery system and a data switch and repository interfaces among these entities to support the delivery (Col. 3, lines 10-15). Freeman further describes that the transactions taking place amongst different entities are monitored by management services to ensure the requirements set by the cooperative are met (Col. 9, lines 17-21), and that the management services also monitors the comparative effectiveness of health care providers (Col. 10, lines 2-5). Freeman fails to teach or suggest a method of managing a healthcare practice participating in an insurance network to optimize the profitability of the healthcare practice with respect to a predetermined reimbursement amount for pharmacy costs.

Segal describes the role of monitoring therapy and managing therapy in pharmaceutical care system (paragraph 7 and Figure 2) and various motivators of behavior change in drug prescribing (paragraph 66). Such motivators includes financial or social/behavior incentives. Segal, however, fails to teach modifying physicians' management behavior regarding the

pharmacy costs to reduce the risk of not receiving the predetermined reimbursement amount from the insurance network thereby optimizing profitability of the healthcare practice.

In view of the above remarks, Freeman in view of Segal fails to teach or even remotely suggest the method of Claim 1. In fact, there is no motivation to combine the teachings of Freeman and Segal.

Item 24, as per Claim 2, Freeman in view of Segal fails to teach the method of Claim 1 as discussed above. Freeman describes a data switch and repository that interfaces amongst different entities and records all transactions to support delivery of a cooperative health care provision (Col. 6, lines 35-41). Freeman fails to teach or suggest databases that provide pharmacy cost information for analyzing and modifying the participating physicians' management behavior regarding the pharmacy costs in order to optimize the profitability of the health practice.

Item 25, as per Claim 5, Freeman in view of Segal fails to teach the method of Claim 1 as discussed above. Segal describes important techniques of academic detailing including educating physicians (paragraph 61), however, Segal fails to teach modifying physicians' management behavior regarding the pharmacy costs to reduce the risk of not receiving the predetermined reimbursement amount from the insurance network thereby optimizing profitability of the healthcare practice.

Item 26, as per Claim 6, Freeman in view of Segal fails to teach the method of Claim 5 as discussed above. Segal describes important techniques of academic detailing (paragraph 61). Segal fails to teach modifying physicians' management behavior regarding the pharmacy costs by preparing a list of prescription medications that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the pharmacy costs. In fact, Segal does not even mention anything about preparing a list of prescription medications or receiving predetermined reimbursement amount for the pharmacy costs.

Item 27, as per Claim 7, Freeman in view of Segal fails to teach the method of Claim 6 as discussed above. Segal describes important techniques of academic detailing (paragraph 61). Segal fails to teach modifying physicians' management behavior regarding the pharmacy costs

by providing custom prescription medication forms that include the list of prescription medications that the at least one physician may prescribe that enable a physician to receive the predetermined reimbursement amount for the pharmacy costs. In fact, Segal does not mention anything about custom prescription medication forms.

Item 28, as per Claim 8, Freeman in view of Segal fails to teach the method of Claim 7 as discussed above. Segal describes important techniques of academic detailing (paragraph 61). Segal fails to teach modifying physicians' management behavior regarding the pharmacy costs by preparing a list of common prescription medications that are approved by insurance networks. In fact, Segal does not mention anything about insurance network.

Item 29, as per Claim 9, Freeman in view of Segal fails to teach the method of Claim 7 as discussed above. Freeman describes that a doctor may access statistical data on all of the patients in the cooperative (Col. 8, lines 54-67). Freeman, however, fails to teach modifying participating physicians' management behavior by analyzing a patient's prescription history.

Item 30, as per Claim 10, Freeman in view of Segal fails to teach the method of Claim 9 as discussed above. Segal describes system interventions which play a role in a pharmaceutical care system (paragraph 6) and so do monitoring therapy and managing therapy (paragraph 7). Segal, however, fails to teach identifying at least one patient whose present prescription medications put the at least one physician at risk for not receiving the predetermined reimbursements for the pharmacy costs or amending/discontinuing the at least one patient's present prescription medications to decrease the at least one physician's risk of not receiving the predetermined reimbursement for the pharmacy costs.

Item 31, as per Claim 11, Freeman in view of Segal fails to teach the method of Claim 10 as discussed above. Segal describes system interventions which play a role in a pharmaceutical care system (paragraph 6) and so do monitoring therapy and managing therapy (paragraph 7). Segal, however, fails to teach modifying participating physicians' management behavior by mailing letters informing the pharmacy and the patient of the discontinuation of the medicine in order to optimize the profitability of the healthcare practice.

Item 32, as per Claim 12, Freeman in view of Segal fails to teach the method of Claim 1 as discussed above. Freeman describes a purchaser database that is built and maintained for the cooperative management system, and that database is updated with new enrollment of health care users whenever a purchasing member has entered the cooperative (Col. 5, line 58 - Col. 6, line 7). Freeman fails to teach or suggest updating the participating physician of any changes in the management of pharmacy costs from the insurance network.

Item 33, as per Claim 13, 14 and 17-23, Applicants submit the similar remarks as presented above as per Claims 1, and 5-12 with the change of "pharmacy costs" to "ancillary medical costs".

Item 34, as per Claim 24, Freeman in view of Segal fails to teach the method of Claim 20 as discussed above. Freeman further describes that the data switch and repository records each transaction amongst different entities and generate reports based on the transactions (Col. 8, lines 44-53). Freeman fails to teach or suggest the groups from which the ancillary medical costs are taken for analyzing and modifying the participating physicians' management behavior in order to optimize the profitability of the healthcare practice.

Item 35, as per Claim 38, Freeman fails to teach the system of Claim 37 as discussed above. Segal describes the role of monitoring therapy and managing therapy in pharmaceutical care system (paragraph 7 and Figure 2) and various motivators of behavior change in drug prescribing (paragraph 66). Such motivators includes financial or social/behavior incentives. Segal fails to teach an identifier for identifying at least one of the plurality of physicians in the healthcare practice participating in the insurance network that is at a greater risk of not receiving a predetermined reimbursement amount for the ancillary medical costs from the insurance network by engaging in ancillary medical procedure that are detrimental to receiving the predetermined reimbursement amount for the ancillary medical costs. In fact, Segal does not mention anything about a risk of not receiving a predetermined reimbursement amount for the ancillary medical costs from the insurance network.

Item 36, as per Claim 50, Freeman fails to teach the system of Claim 49 as discussed above. Segal describes the role of monitoring therapy and managing therapy in pharmaceutical

care system (paragraph 7 and Figure 2) and various motivators of behavior change in drug prescribing (paragraph 66). Such motivators includes financial or social/behavior incentives. Segal fails to teach an identifier for identifying at least one of the plurality of physicians in the healthcare practice participating in the insurance network that is at a greater risk of not receiving a predetermined reimbursement amount for the ancillary medical costs from the insurance network by engaging in ancillary medical procedure that are detrimental to receiving the predetermined reimbursement amount for the ancillary medical costs. In fact, Segal does not mention anything about a risk of not receiving a predetermined reimbursement amount for the ancillary medical costs from the insurance network.

In view of the above remarks, Applicants believe that the combination of Freeman in view of Segal neither rises to the level of a proper prima facie 35 U.S.C. §103 rejection nor renders obvious Claims 1, 2, 5-14, 17-23, 24, 38 and 50. One skilled artisan would not have produced the present invention based on the teachings or suggestions of Freeman and Segal, alone or combined. Therefore, Applicants respectfully request that the rejection of Claims 1, 2, 5-14, 17-23, 24, 38 and 50 under 35 U.S.C. §103 be withdrawn.

35 U.S.C. §103 Rejection

Claims 28 and 29 stand rejected under 35 U.S.C. §103 as being unpatentable over Freeman in view of Glass. This rejection is respectfully traversed.

Applicants believe that the Examiner's rejection is improper for at least three reasons. First, each of Freeman and Glass fails to disclose or suggest what the Examiner alleges it discloses. Instead, Applicants believe that the Examiner has improperly taken elements from each of Freeman and Glass out of context. Second, because there is no evidence of motivation to combine these documents, Applicants believe that the Examiner has used improper hindsight by using Applicants' patent application disclosure as a road map to then piecemeal elements from these Freeman and Glass documents together in an attempt to reject the claims. Third, Applicants also believe that even if these documents were somehow combinable, the result of the combination would not be the claimed invention. In detail, Applicants wish to present the following remarks.

Freeman describes a system and method for supporting delivery of health care. Specifically, Freeman describes a data switch and repository that records all of the transactions among the provider, insurance company and financial institution (see Col. 2, lines 50-55), and a method of utilizing such data switch and repository to support an agency-cooperative health care provision and management (see Col. 2, lines 8-26). Freeman fails to teach or suggest a method of optimizing the profitability of an insurance network having a plurality of physicians in a healthcare practice participating therein by managing medical costs. The system and method described in Freeman is directed to the purpose of effectuating the operation of a cooperative agency organization dedicated to health care provision and management amongst a plurality of entities (see Col. 3, lines 7-16) rather than optimizing the profitability of an insurance network.

In contrast, the present invention teaches a method of optimizing a health care insurance network as stated in Claim 25. Such method is focused on managing medical costs of participating physicians. In view of this, Freeman fails to teach the method of Claim 25. Claim 27 is dependent of Claim 26, which is dependent of Claim 25. Therefore, Freeman fails to teach the method of Claim 27.

Glass describes incentive-based physician compensation models. Glass further describes that a physician can be rewarded for being cost-effective (paragraph 51). Glass indicates identifying a physician who has actual costs less than budgeted costs for a bonus reward. Glass, however, fails to teach identifying a physician who has ancillary medical costs greater than the average costs per physician for the healthcare practice. Furthermore, Glass fails to teach any method for optimizing a health care insurance network as claimed in the present invention.

Item 39, as per Claim 29, Freeman fails to teach the method of Claim 27 as discussed above. Glass describes that a physician can be rewarded for being cost-effective (paragraph 51). Glass indicates identifying a physician who has actual costs less than budgeted costs for a bonus reward. Glass, however, fails to teach selecting at least one physician having the highest ancillary medical costs within the healthcare practice. Furthermore, Glass fails to teach any method for optimizing a health care insurance network as claimed in the present invention.

In view of the above remarks, Applicants believe that the combination of Freeman in view of Glass neither rises to the level of a proper prima facie 35 U.S.C. §103 rejection nor renders obvious Claims 28 and 29. One skilled artisan would not have produced the present invention based on the teachings or suggestions of Freeman and Glass, alone or combined. Therefore, Applicants respectfully request that the rejection of Claims 28 and 29 under 35 U.S.C. §103 be withdrawn.

35 U.S.C. §103 Rejection

Claims 3, 4, 15, 16, 30-34, 39-45 and 51-56 stand rejected under 35 U.S.C. §103 as being unpatentable over Freeman in view of Segal and further in view of Glass. This rejection is respectfully traversed.

Applicants believe that the Examiner's rejection is improper for at least three reasons. First, each of Freeman, Segal and Glass fails to disclose or suggest what the Examiner alleges it discloses. Instead, Applicants believe that the Examiner has improperly taken elements from each of Freeman, Segal and Glass out of context. Second, because there is no motivation to combine these documents, Applicants believe that the Examiner has used improper hindsight by using Applicants' patent application disclosure as a road map to then piecemeal elements from these Freeman, Segal and Glass documents together in an attempt to reject the claims. Third, Applicants also believe that even if these documents were somehow combinable, the result of the combination would not be the claimed invention. In detail, Applicants wish to present the following remarks.

Freeman describes a system and method for supporting delivery of health care. Specifically, Freeman describes a data switch and repository that records all of the transactions among the provider, insurance company and financial institution (see Col. 2, lines 50-55), and a method of utilizing such data switch and repository to support an agency-cooperative health care provision and management (see Col. 2, lines 8-26). Freeman fails to teach or suggest a method of optimizing the profitability of an insurance network having a plurality of physicians in a healthcare practice participating therein by managing medical costs. The system and method described in Freeman is directed to the purpose of effectuating the operation of a cooperative

agency organization dedicated to health care provision and management amongst a plurality of entities (see Col. 3, lines 7-16) rather than optimizing the profitability of an insurance network.

Segal describes drug prescribing and drug use process in a pharmaceutical care system. Segal fails to teach anything regarding a method of managing a healthcare practice participating in an insurance network to optimize the profitability of the healthcare practice with respect to a predetermined reimbursement amount for pharmacy costs or selected ancillary medical costs. Nor does Segal teach or suggest a healthcare management optimizing system.

Glass describes incentive-based physician compensation models. Glass further describes that a physician can be rewarded for being cost-effective (paragraph 51). Glass indicates identifying a physician who has actual costs less than budgeted costs for a bonus reward. Glass, however, fails to teach identifying a physician who has ancillary medical costs greater than the average costs per physician for the healthcare practice. Furthermore, Glass fails to teach any method for optimizing a health care insurance network as claimed in the present invention.

In contrast, the present invention teaches a method of managing a healthcare practice to optimize profitability of the healthcare practice and related systems. Such method and systems are focused on modifying participating physicians' management behavior regarding the pharmacy costs or ancillary medical costs to reduce the risk of not receiving the predetermined reimbursement amount from the insurance network.

Item 41, as per Claim 3, Freeman in view of Segal fails to teach the method of Claim 2 as discussed above. Glass describes that a physician can be rewarded for being cost-effective (paragraph 51). Glass indicates identifying a physician who has actual costs less than budgeted costs for a bonus reward. Glass, however, fails to teach identifying a physician who has pharmacy costs greater than the average pharmacy costs per physician for the healthcare practice. Furthermore, Glass fails to teach any method for optimizing profitability of the healthcare practice as claimed in the present invention.

Item 42, as per Claim 4, Freeman in view of Segal and Glass fails to teach the method of Claim 3 as discussed above. Glass describes that a physician can be rewarded for being cost-effective (paragraph 51). Glass indicates identifying a physician who has actual costs less than

budgeted costs for a bonus reward. Glass, however, fails to teach selecting at least one physician having the highest ancillary medical costs within the healthcare practice. Furthermore, Glass fails to teach any method for optimizing profitability of a healthcare practice as claimed in the present invention.

Item 43, as per Claims 15 and 16, Applicants submit the similar remarks as presented above as per Claims 3 and 4 with the change of "pharmacy costs" to "ancillary medical costs".

Item 44, as per Claim 30, Freeman in view of Glass fails to teach the method of Claim 28 as discussed above. Segal describes important techniques of academic detailing including educating physicians (paragraph 61). Segal, however, fails to teach modifying physicians' management behavior regarding the ancillary medical costs by educating the physicians on alternative ancillary medical procedures and organizing continued medical education classes for the physicians. In fact, Segal does not even mention anything about optimizing profitability of the insurance network.

Item 45, as per Claim 31, Freeman in view of Segal and Glass fails to teach the method of Claim 30 as discussed above. Segal describes important techniques of academic detailing including educating physicians (paragraph 61). Segal, however, fails to teach modifying physicians' management behavior regarding the ancillary medical costs by preparing a list of ancillary medical procedure that are more profitable to the insurance network. In fact, Segal does not even mention anything about optimizing profitability of the insurance network.

Item 46, as per Claim 32, Freeman in view of Segal and Glass fails to teach the method of Claim 31 as discussed above. Segal describes important techniques of academic detailing including educating physicians (paragraph 61). Segal, however, fails to teach modifying physicians' management behavior regarding the ancillary medical costs by providing custom ancillary medical procedure forms that include the medical procedures that are more profitable to the insurance network. In fact, Segal does not even mention anything about optimizing profitability of the insurance network.

Item 47, as per Claim 33, Freeman in view of Segal and Glass fails to teach the method of Claim 32 as discussed above. Segal describes system interventions which play a role in a

pharmaceutical care system (paragraph 6) and so do monitoring therapy and managing therapy (paragraph 7). Segal, however, fails to teach identifying at least one patient whose present prescription medications put the at least one physician at risk for not receiving the predetermined reimbursements for the pharmacy costs or amending the at least one patient's present prescription medications to procedures that are more profitable to the insurance network.

Item 48, as per Claim 34, Freeman in view of Segal and Glass fails to teach the method of Claim 33 as discussed above. Segal describes system interventions which play a role in a pharmaceutical care system (paragraph 6) and so do monitoring therapy and managing therapy (paragraph 7). Segal, however, fails to teach modifying participating physicians' management behavior by mailing letters informing the pharmacy and the patient of the amendment of the patient's medical procedure in order to optimize the profitability of the insurance network.

Item 49, as per Claim 39, Freeman in view of Segal fails to teach the method of Claim 38 as discussed above. Glass describes that a physician can be rewarded for being cost-effective (paragraph 51). Glass indicates identifying a physician who has actual costs less than budgeted costs for a bonus reward. Glass, however, fails to teach identifying a physician who has pharmacy costs greater than the average pharmacy costs per physician for the healthcare practice. Furthermore, Glass fails to teach any system for optimizing profitability of the healthcare practice as claimed in the present invention.

Item 50, as per Claim 40, Freeman in view of Segal and Glass fails to teach the method of Claim 39 as discussed above. Segal describes important techniques of academic detailing including educating physicians (paragraph 61). Segal, however, fails to teach modifying physicians' management behavior regarding the ancillary medical costs by educating the physicians on alternative ancillary medical procedures and organizing continued medical education classes for the physicians. In fact, Segal does not even mention anything about optimizing profitability of the healthcare practice.

Item 51, as per Claim 41, Freeman in view of Segal and Glass fails to teach the method of Claim 40 as discussed above. Segal describes important techniques of academic detailing including educating physicians (paragraph 61). Segal, however, fails to teach modifying

physicians' management behavior regarding the ancillary medical costs by providing custom ancillary medical procedure forms that include the medical procedures that are preferred by the insurance network. In fact, Segal does not even mention anything about optimizing profitability of the healthcare practice.

Item 52, as per Claim 42, Freeman in view of Segal and Glass fails to teach the method of Claim 41 as discussed above. Segal describes system interventions which play a role in a pharmaceutical care system (paragraph 6) and so do monitoring therapy and managing therapy (paragraph 7). Segal, however, fails to teach identifying at least one patient whose present prescription medications are not preferred by the insurance network or amending the at least one patient's present prescription medications to procedures that are preferred by the insurance network.

Item 53, as per Claim 43, Freeman in view of Segal and Glass fails to teach the method of Claim 42 as discussed above. Segal describes system interventions which play a role in a pharmaceutical care system (paragraph 6) and so do monitoring therapy and managing therapy (paragraph 7). Segal, however, fails to teach mailing letters informing the pharmacy and the patient of the amendment of the patient's medical procedure in order to optimize the profitability of the healthcare practice. In fact, Segal does not even mention anything about optimizing profitability of the healthcare practice.

Item 54, as per Claim 44, Freeman in view of Segal and Glass fails to teach the method of Claim 43 as discussed above. Furthermore Freeman describes a purchaser database that is built and maintained for the cooperative management system, and that database is updated with new enrollment of health care users whenever a purchasing member has entered the cooperative (Col. 5, line 58 - Col. 6, line 7). Freeman fails to teach or suggest updating the participating physician of new ancillary medical procedures that are more profitable to the insurance network. Freeman's database updating has nothing to do with new ancillary medical procedures.

Item 55, as per Claim 45, Freeman in view of Segal and Glass fails to teach the method of Claim 44 as discussed above. Furthermore Freeman describes that the data switch and repository records each transaction amongst different entities and generate reports based on the transactions

(Col. 8, lines 44-53). Freeman fails to teach or suggest groups from which the ancillary medical costs are taken for analyzing and further updating participating physician of new ancillary medical procedures that are more profitable to the insurance network.

Item 56, as per Claim 51, Freeman in view of Segal and Glass fails to teach the method of Claim 50 as discussed above. Glass describes that a physician can be rewarded for being cost-effective (paragraph 51). Glass indicates identifying a physician who has actual costs less than budgeted costs for a bonus reward. Glass, however, fails to teach identifying a physician who has pharmacy costs greater than the average pharmacy costs per physician for the healthcare practice. Furthermore, Glass fails to teach any system for optimizing profitability of the healthcare practice as claimed in the present invention.

Item 57, as per Claim 52, Freeman in view of Segal and Glass fails to teach the method of Claim 51 as discussed above. Segal describes important techniques of academic detailing including educating physicians (paragraph 61). Segal, however, fails to teach modifying physicians' management behavior regarding the ancillary medical costs by educating the physicians on alternative ancillary medical procedures and organizing continued medical education classes for the physicians. In fact, Segal does not even mention anything about optimizing profitability of the healthcare practice.

Item 58, as per Claim 53, Freeman in view of Segal and Glass fails to teach the method of Claim 52 as discussed above. Segal describes important techniques of academic detailing including educating physicians (paragraph 61). Segal, however, fails to teach modifying physicians' management behavior regarding the ancillary medical costs by providing custom ancillary medical procedure forms that include the medical procedures that are preferred by the insurance network. In fact, Segal does not even mention anything about optimizing profitability of the healthcare practice.

Item 59, as per Claim 54, Freeman in view of Segal and Glass fails to teach the method of Claim 53 as discussed above. Segal describes system interventions which play a role in a pharmaceutical care system (paragraph 6) and so do monitoring therapy and managing therapy (paragraph 7). Segal, however, fails to teach identifying at least one patient whose present

prescription medications are not preferred by the insurance network or amending the at least one patient's present prescription medications to procedures that are preferred by the insurance network.

Item 60, as per Claim 55, Freeman in view of Segal and Glass fails to teach the method of Claim 54 as discussed above. Segal describes system interventions which play a role in a pharmaceutical care system (paragraph 6) and so do monitoring therapy and managing therapy (paragraph 7). Segal, however, fails to teach mailing letters informing the ancillary medical facility and the patient of the amendment of the patient's medical procedure in order to optimize the profitability of the healthcare practice. In fact, Segal does not even mention anything about optimizing profitability of the healthcare practice.

Item 61, as per Claim 56, Freeman in view of Segal and Glass fails to teach the method of Claim 55 as discussed above. Freeman further describes that the data switch and repository records each transaction amongst different entities and generate reports based on the transactions (Col. 8, lines 44-53). Freeman fails to teach or suggest groups from which the ancillary medical costs are taken for analyzing and further for generating letters to inform the ancillary medical facility and the patient of the amendment of the patient's medical procedure in order to optimize the profitability of the healthcare practice.

In view of the above remarks, Applicants believe that the combination of Freeman in view of Segal and further in view of Glass neither rises to the level of a proper prima facie 35 U.S.C. §103 rejection nor renders obvious Claims 3, 4, 15, 16, 30-34, 39-45 and 51-56. One skilled artisan would not have produced the present invention based on the teachings or suggestions of Freeman, Segal and Glass, alone or combined. Therefore, Applicants respectfully request that the rejection of Claims 3, 4, 15, 16, 30-34, 39-45 and 51-56 under 35 U.S.C. §103 be withdrawn.

CONCLUSION

In view of the amendments and remarks set forth herein, Applicants respectfully submit that the application is in condition for allowance. Accordingly, the issuance of a Notice of Allowance in due course is respectfully requested.

Respectfully submitted,

Jeffrey Whittle
Reg. No. 36,382

Date: 7/1/03

BRACEWELL & PATTERSON, L.L.P.
P.O. Box 61389
Houston, Texas 77208-1389
Telephone: (713) 221-1185

1541787v1